



PHOENIX

Phoenix Life Insurance Company
 PHL Variable Insurance Company

PO Box 8027
Boston MA 02266-8027
Underwriting and Issue

Application Part II

Company is defined as indicated

Examination to be made in private. Please read all questions to applicant. Answers to be recorded in the examiner's own handwriting.

NAME OF PROPOSED INSURED SEX DATE OF BIRTH OCCUPATION

Table with 5 columns: Family Record, Age, Health, Age At Death, Cause of Death. Rows include Father, Mother, Brothers & Sisters (No. Living, No. Dead).

6. Name of personal physician (If none, so state)
Address
Date last seen, Reason and Outcome

- 2. To your knowledge, have any of your parents, brothers or sisters had diabetes?
3. A. Have you ever been treated for alcoholism or any drug habit?
B. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or any prescription drug except in accordance with a physician's instructions?
4. Have you sought treatment or consulted a physician for any reason in the last 5 years, including routine examinations or check-ups? (Give full details.)
5. To the best of your knowledge have you ever had, or been told by any physician or other practitioner that you had:
A. High blood pressure?
B. Pain, pressure, or discomfort in the chest, palpitation, swelling of the ankles, or undue shortness of breath?
C. Heart disease, heart murmur, angina pectoris, or coronary disease?
D. Rheumatic fever, chorea, rheumatism, or arthritis?
E. Pneumonia, pleurisy, asthma, tuberculosis, chronic cough, or any other disease of the lungs?
F. Epilepsy, fainting spells, concussion, skull fracture, severe headaches, dizziness, mental disorder or nervous breakdown?
G. Indigestion, stomach or duodenal ulcer, colitis, or other disease of the intestines or rectum, gall bladder disorder, jaundice, hepatitis, or liver disorder?
H. Kidney disease, nephritis, kidney stone, bladder trouble, or albumin, sugar, pus, or blood in the urine?
I. Disease of the reproductive organs, prostate trouble, abnormal menstruation, complicated pregnancies or disease of the breasts?
J. Diabetes, venereal disease, gout, thyroid disease, enlarged glands, tumor, polyp, cancer or skin disease?
K. Anemia, bleeding or clotting disorder, or any other disease of the blood or bone marrow? (except HIV status)
L. Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or any other immunological disease or disorder? (except HIV status)
M. Paralysis, deformity, or any injury or disorder of the muscles, bones, joints, spine or back?
N. Other than above, any physical or mental disorder, operation, or injury within the past 5 years?

- 7. A. Have you ever had a surgical operation or been a patient in any hospital, sanatorium, or similar institution?
B. Have you had, or been advised to have, any surgical operations, X-rays, electrocardiograms, blood studies, or other tests within the last 5 years?
C. Has a physician ever advised you to diet?
D. Is there any kind of medicine which you take regularly or at frequent intervals?
8. A. Have you ever been declined, postponed, rated, or ridered for insurance?
B. Are you negotiating for other insurance? (If "yes" name companies and amounts.)

9. DETAILS of all questions answered "yes." Include Dates, Names, and Addresses of all doctors consulted, Duration, Treatment, and Results. Please indicate question # you are responding to:
Question #

The foregoing statements are full, complete, and true to the best of my knowledge and belief.

DATED AT (City and State) DATE
WITNESS (Examiner) PROPOSED INSURED (SIGN FULL NAME)

PARAMEDICAL EXAMINATION – Complete questions 1-11.

MEDICAL EXAMINATION BY PHYSICIAN – Complete all questions.

1. **How did you identify applicant?** Driver's license (Please provide number and state) _____
 Other (Specify) _____

2. Height: <input type="checkbox"/> measured <input type="checkbox"/> not measured If not measured, indicate reason below.	3. Weight: <input type="checkbox"/> measured <input type="checkbox"/> not measured If not measured, indicate reason below.	4. Change in Weight: Has applicant's weight changed by 10 pounds or more in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", how much: _____ pounds <input type="checkbox"/> Gain <input type="checkbox"/> Loss Reason for weight change: _____
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5. Pulse Rate: <input type="checkbox"/> regular <input type="checkbox"/> irregular If pulse is irregular, give details below.	6. Blood Pressure: If systolic BP above 140 or diastolic BP above 90, record 2 additional BP readings at least 5 minutes apart.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">1st BP Reading:</td> <td style="width:33%;">2nd BP Reading:</td> <td style="width:33%;">3rd BP Reading:</td> </tr> <tr> <td colspan="3">Size of BP cuff used: <input type="checkbox"/> Standard cuff <input type="checkbox"/> Large cuff <input type="checkbox"/> Small cuff</td> </tr> </table>	1st BP Reading:	2nd BP Reading:	3rd BP Reading:	Size of BP cuff used: <input type="checkbox"/> Standard cuff <input type="checkbox"/> Large cuff <input type="checkbox"/> Small cuff		
1st BP Reading:	2nd BP Reading:	3rd BP Reading:						
Size of BP cuff used: <input type="checkbox"/> Standard cuff <input type="checkbox"/> Large cuff <input type="checkbox"/> Small cuff								

7. Is applicant pregnant? If "yes," please provide due date <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Does applicant appear unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Does applicant use a wheelchair, cane, crutches, walker, or any other assistive device for walking? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Is there any indication of confusion or forgetfulness? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Are you aware of any other information that is pertinent to the applicant's life expectancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please provide details of any "YES" answers, abnormal findings, or additional remarks:
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PHYSICIAN EXAMINATION ONLY:

12. On examination, is there any abnormality of the following: (a) HEENT (include thyroid exam) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) CNS (gait, tremor, weakness, paralysis) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) Cardiovascular (If abnormal heart sounds or murmurs are present, please describe fully and give your impression. Also check for peripheral edema or any evidence of peripheral vascular disease.) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) Respiratory (breath sounds, wheezing, rales) <input type="checkbox"/> Yes <input type="checkbox"/> No (e) Abdomen (surgical scars, ascites) <input type="checkbox"/> Yes <input type="checkbox"/> No (f) Musculoskeletal (joints, amputations, deformities) <input type="checkbox"/> Yes <input type="checkbox"/> No (g) Lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No (h) Skin (surgical scars, rash, or any possibly significant skin lesions) <input type="checkbox"/> Yes <input type="checkbox"/> No	
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TESTING PERFORMED IN CONJUNCTION WITH THIS EXAMINATION:

<input type="checkbox"/> Blood sample	<input type="checkbox"/> Electrocardiogram
<input type="checkbox"/> Urine specimen (if female applicant currently menstruating, check here <input type="checkbox"/>)	<input type="checkbox"/> Chest X-ray

Which lab was SMAC/SPEC sent to? _____

EXAMINER'S STATEMENT:
 I certify that I have carefully examined _____ and that the applicant's responses to all questions on both sides of this form are accurately recorded. (print name of person examined)

Examiner's Signature	Date of Examination	Time of Examination <input type="checkbox"/> AM <input type="checkbox"/> PM
Examiner's Tax ID Number	Name of Producer Requesting Examination	
Examiner's Printed Name	Producer & Agency Code	
Examiner's Address	Place of Examination (City, State)	<input type="checkbox"/> Examiner's office <input type="checkbox"/> Applicant's business <input type="checkbox"/> Applicant's residence

AUTHORIZATION FOR USE WHEN APPLYING FOR FAMILY COVERAGE

REQUEST FOR INTERVIEW

We do We do not (check one only) require that we be interviewed in connection with any investigative consumer report that may be prepared.

AUTHORIZATION TO OBTAIN INSURANCE (NONMEDICAL) INFORMATION

We hereby authorize any insurance company to which we have applied for or inquired about insurance coverage or benefits to give to the Phoenix Home Life Mutual Insurance Company or its reinsurers any information relating to or obtained in connection with such application or inquiry including the dollar amounts and status of any policies or claims.

AUTHORIZATION TO OBTAIN HEALTH CARE (MEDICAL) INFORMATION

We hereby authorize any physician, hospital, clinic or other health care provider or any persons who have health care information about us or our family, including insurance companies and MIB, Inc., to give that information to the Phoenix Home Life Mutual Insurance Company. Phoenix may then redisclose it to other persons, including MIB, Inc., legal representatives, medical consultants, reinsurance companies and consumer reporting agencies, only to the extent required to perform their services for the Company. The information may also be redisclosed as otherwise required or permitted by law. The information will not be given, sold or transferred to any other person not mentioned in this authorization. If the record contains information relating to alcohol or drug abuse or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested. This information may be used only for the purpose of risk evaluation, the administration of claims and implementation of policy provisions and for insurance statistical studies.

This authorization or a true photocopy thereof shall continue to be valid for 30 months from the date signed below unless otherwise required by law. It may be revoked in writing to the company at any time until the insurance coverage has been placed in force. We may receive a copy of it on request. It is understood that this authorization applies separately to each person applying for insurance.

We acknowledge that we have received a copy of the Pre-Notification to applicants regarding the Medical Information Bureau, Investigative Consumer Reports and the Underwriting Process.

DATE

PROPOSED INSURED (SIGN FULL NAME)

SPOUSE OF PROPOSED INSURED (SIGN FULL NAME)

WHAT YOU SHOULD KNOW ABOUT THE UNDERWRITING PROCESS

One of the prime objectives of Phoenix Home Life Mutual Insurance Company is to provide insurance at low cost. The underwriting process - the evaluation of risks - is necessary not only to assure this low cost, but also to assure that each policyholder contributes his or her fair share of the cost.

Your **application** is the primary source of information in the evaluation process. However, as authorized by you, other sources of information may be used. These include the results of your **physical examination**, if required, and any reports received from **doctors** or **hospitals** who have attended you.

A check of the records of the **Medical Information Bureau** will be made. The purpose of the Bureau is to protect member companies and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the Bureau serves as an alert to the possible need for further independent investigation, but except in limited circumstances under Bureau rules, cannot itself be used as the basis for rating or declination. The Bureau is not a repository of medical reports from hospitals and doctors, and information in the Bureau file does not reveal whether applications for insurance are accepted, rated or declined.

In addition, it is common practice within the insurance business to obtain an **investigative consumer report** as described on the reverse side. While these are not obtained on all cases, in the event that such a report is obtained, the applicant may, on request, be given the name and address of the reporting agency.

In most instances, our applicants are in good health, are not subject to unusual accident hazards, and otherwise meet our underwriting standards. In these cases, the applications are rather quickly approved and a policy is issued at standard rates.

Some applicants for insurance, however, present greater insurance risks. This is usually due to an abnormal physical condition, a possibly dangerous occupation or avocation or a history of medical problems. In these cases a higher premium may be charged or coverage may be limited. In this way, each policy owner assumes his or her fair share of the insurance cost.

Occasionally, an applicant is denied coverage, usually because of a past or present medical condition. Whatever cash may have been collected is, of course, promptly returned.

For the benefit of all our policyholders, Phoenix selects you as carefully as you selected us. The Company's continuing objective is to provide you with low cost insurance coupled with sound and timely advice, both now and in the years to come.

Thank you for applying to Phoenix.

NEW BUSINESS PRE-NOTICE INFORMATION FOR PROPOSED INSURED

As part of the selection procedure in the underwriting of your application to Phoenix, you may be contacted to complete a New Business Interview. This personal history report will be conducted by a member of our Office staff. Any information which you may discuss with interviewer will be used for underwriting purposes only. It will not be divulged to any outside source and is considered a confidential communication between you and Phoenix. Thank you for your cooperation.



100 Bright Meadow Boulevard
P.O. Box 1900
Enfield, CT 06083-1900

Authorization and Prenotification Forms

REQUEST FOR INTERVIEW

I do I do not (check one only) require that I be interviewed in connection with any investigative consumer report that may be prepared.

AUTHORIZATION TO OBTAIN INSURANCE (NONMEDICAL) INFORMATION

I hereby authorize any insurance company to which I have applied for or inquired about insurance coverage or benefits to give to the Phoenix Home Life Mutual Insurance Company or its reinsurers any information relating to or obtained in connection with such application or inquiry including the dollar amounts and status of any policies or claims.

AUTHORIZATION TO OBTAIN HEALTH CARE (MEDICAL) INFORMATION

I hereby authorize any physician, hospital, clinic or other health care provider or any persons who have health care information about me, including insurance companies and MIB, Inc., to give that information to the Phoenix Home Life Mutual Insurance Company. Phoenix may then redisclose it to other persons, including MIB, Inc.; legal representatives, medical consultants, reinsurance companies and consumer reporting agencies, only to the extent required to perform their services for the Company. The information may also be redisclosed as otherwise required or permitted by law. The information will not be given, sold or transferred to any other person not mentioned in this authorization. If the record contains information relating to alcohol or drug abuse or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested. This information may be used only for the purpose of risk evaluation, the administration of claims and implementation of policy provisions and for insurance statistical studies.

This authorization or a true photocopy thereof shall continue to be valid for 30 months from the date signed below unless otherwise required by law. It may be revoked in writing to the company at any time until the insurance coverage has been placed in force. I may receive a copy of it on request.

I acknowledge that I have received a copy of the Pre-Notification to applicants regarding the Medical Information Bureau, Investigative Consumer Reports and the Underwriting Process.

DATE	FIRST PROPOSED INSURED (Sign full name)	SECOND PROPOSED INSURED (SIGN FULL NAME)
OL 910 12-91	(If applying for family coverage, spouse & proposed insured sign authorization on the reverse side)	

PRE-NOTIFICATION REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Phoenix may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or submit a claim for benefits to such company, the Bureau, upon request, will supply such company with the information it may have.

Phoenix may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The Company will not, however, reveal to another company or to the Bureau, the action taken on the basis of your current request for insurance.

Upon request, the Bureau will arrange disclosure of information in your file. (Nonmedical information will be disclosed to you and medical information will be disclosed to your attending physician or other medical professional designated by you.) If you question the accuracy of the information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's information office is at P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone 617-426-3660.

PRE-NOTIFICATION OF INVESTIGATIVE CONSUMER REPORT TO INSURANCE/ANNUITY APPLICANT

In compliance with the provisions of the Fair Credit Reporting Act, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report, which includes information regarding the consumer's character, general reputation, personal characteristics, and mode of living, is obtained through personal interviews with friends, neighbors and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of such a report, if one is made, will be provided.

SUPPLEMENTARY NOTICE OF INFORMATION PRACTICES

In addition to the information practices described in the pre-notification entitled "What You Should Know About the Underwriting Process", "Investigative Consumer Reports", and "Medical Information Bureau", we and your agent may, under limited circumstances, disclose certain of the information gathered to third parties without your further authorization. For example, certain necessary items of information may be disclosed to:

- persons or organizations for purposes of performing a business, professional or insurance function for use in connection with risk evaluation, administration of claims, and implementation of policy provisions;
- a medical professional to inform you of a medical condition of which you may not be aware;
- a state insurance department for purposes of carrying out its regulatory responsibilities;
- an affiliated company so that it can inform you of the availability of an insurance product or service.

Please also note that, in the event we ask a consumer reporting agency to gather information for us, the information obtained may be kept by it and later disclosed to other users of reports. You have the right to request to be interviewed in connection with the preparation of any investigative consumer report that may be prepared.

You have a right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. A description of these procedures will be sent to you upon request. If you have any further questions about our information practices, please write to: Medical Director, Phoenix Home Life Mutual Insurance Company, 100 Bright Meadow Blvd., P.O. Box 1900, Enfield, CT 06083-1900

